

**Complaint Form  
WIC Nutrition Program/CSFP**

<p><b>PERSON FILING COMPLAINT</b> (Please Print)</p> <p>Name _____</p> <p>Address _____</p> <p>City, State &amp; Zip _____</p> <p>Telephone Number _____</p>	<p align="center"><b>Originating Clinic Name</b></p> <p align="center">_____</p> <p align="center"><b>Date Form Filled Out</b></p> <p align="center">_____</p>	<p align="center">FOR OFFICE USE ONLY</p> <p>Civil Rights <input type="checkbox"/> Other <input type="checkbox"/></p> <p>Date Received at State Office _____</p> <p><b>Time Spent: Hr. _____ Min. _____</b></p>
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**PERSON MAKING COMPLAINT IS A:**

**Participant Name:** \_\_\_\_\_

**Vendor and #:** \_\_\_\_\_

**WIC Staff Name:** \_\_\_\_\_

**CSFP Staff Name:** \_\_\_\_\_

**Other (specify):** \_\_\_\_\_

**WHO IS THE COMPLAINT CONCERNING?:**

**Participant Name:** \_\_\_\_\_

**Vendor and #:** \_\_\_\_\_

**WIC Staff Name:** \_\_\_\_\_

**CSFP Staff Name:** \_\_\_\_\_

**Other (specify):** \_\_\_\_\_

**DETAILS OF THE COMPLAINT:**

Date of Incident: \_\_\_\_\_ Time: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Name and/or description of individuals involved (if available): \_\_\_\_\_

**Please describe in your own words what happened to cause the complaint. Be as specific as possible. Please indicate as many details as you can recall. *If this is regarding a Vendor issue, please attach a copy of your grocer receipt.* (Add additional pages or continue on the back of this form.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Person Filing Complaint

\_\_\_\_\_  
Signature of Person Filling Out the Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

**SEND COMPLETED FORM TO:**

WIC Nutrition Program  
Public Health Division  
New Mexico Department of Health  
2040 South Pacheco Street  
Santa Fe, New Mexico 87505  
**FAX Number: (505) 476-8900**

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**DRAFT** Revised 7/06